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Supreme Court, U.S.
FILED
MAY 18 2005
OFFICE OF THE CLERK

No. 04-1395

IN THE

Supreme Court of the United States

LINDA ELLIS,

Petitioner,

v.

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether, based on the substantial evidence contained in the administrative record, Liberty Life Assurance Company of Boston ("Liberty" or the "Company") abused its discretion in terminating Linda Ellis' ("Ellis") ERISA-covered disability benefits.

RULE 29.6 STATEMENT

Liberty Life Assurance Company of Boston states that it has the following parent corporations:

Liberty Mutual Holding Company Inc.
LMHC Massachusetts Holdings Inc.
Liberty Mutual Group Inc.
Liberty Mutual Insurance Company
Liberty Mutual Fire Insurance Company

Liberty Mutual Holding Company Inc. owns 100% of the stock of LMHC Massachusetts Holdings Inc. which owns 100% of the stock of Liberty Mutual Group Inc. Liberty Mutual Group Inc. owns 100% of the stock of Liberty Mutual Insurance Company and 100% of the stock of Liberty Mutual Fire Insurance Company. Liberty Mutual Insurance Company owns 90% of the stock and Liberty Mutual Fire Insurance Company owns 10% of the stock of Liberty Life Assurance Company of Boston. No publicly held company owns 10% or more of the stock of Liberty Life Assurance Company of Boston.

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STATUTES INVOLVED

Ellis' list of involved statutes is over-inclusive. Sections 1132(a)(1)(A), 1132(a)(2), and 1132(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA") are not at issue in this case. Rather, the only section of ERISA relevant to the disposition of this matter is 29 U.S.C. § 1132(a)(1)(B) which provides:

> **(a) Persons empowered to bring a civil action**
>
> A civil action may be brought —
>
> **(1)** by a participant or beneficiary —
>
> . . .
>
> **(b)** to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. . . .

(emphasis in original) 29 U.S.C. § 1132(a)(1)(B).

STATEMENT OF THE CASE

This case presents nothing more than a run-of-the-mill insurance benefits dispute that neither the panel nor Fifth Circuit *en banc* deemed worthy of reconsideration. Indeed, as of the filing of this response, no Circuit Court of Appeals has cited this case and, of the district courts referencing this matter, not one has indicated disagreement with the holding or analysis of the Fifth Circuit.

In November 1999, Ellis, a former Chase Manhattan Bank ("Chase" or the "Bank") loan officer, went on medical

leave from the Bank, contending that she was totally disabled from working at the Bank (or anywhere else) in any capacity. The loan officer job that Ellis used to perform involves the processing of loan applications for Chase customers and is purely sedentary in nature.

Liberty is a nationwide insurance carrier. The Company issued a group long term disability insurance policy (the "Policy") to the Bank in January 1997. The Policy, which forms part of Chase's employee welfare benefits plan under ERISA, provides long term disability benefits to eligible Bank employees. As the Policy's insurer, Liberty possesses the sole authority to make all coverage, eligibility, and interpretation decisions concerning the Policy.

Under the terms of the Policy, a Chase employee may be eligible for "total," "partial" (also known as a "work incentive benefits"), or no disability benefits at all. Total disability benefits are payable for the first 24 months of disability to an employee who is "unable to perform all of the material and substantial duties of [her] occupation on an Active Employment basis because of an Injury or Sickness" and after 24 months, benefits are payable if the employee "is unable to perform with reasonable continuity, all of the material and substantial duties of [her] own or any other occupation for which [she] is or becomes reasonably filled by training, education, experience, age and physical and mental capacity."

In turn, work incentive benefits may be available to an eligible Bank employee or ex-employee who is "partially disabled," meaning "able to perform one or more, but not all, of the material and substantial duties of [her] occupation *on an Active Employment or part-time basis*; or . . . able to perform all of the material and substantial duties of [her] own or any other occupation *on a part-time basis*." As the terms "Active employment," "part-time basis," and "work

incentive" imply, such benefits are only available to persons who are, in fact, employed in some capacity during the relevant time frame.[1] Ellis, however, at least during the administrative process, never asserted that she was partially disabled and, therefore, entitled to work incentive benefits. Rather, she argued that she was unable to work anywhere in any capacity. Consistent with her representations, Liberty determined that Ellis was, in fact, unemployed between the time she applied for benefits and the final disposition of her claim. Consequently, the partial disability, or "work incentive," provisions of the Policy do not apply to Ellis.

Nevertheless, between December 1999 and May 2000, Ellis did receive some compensation. For instance, she qualified for group short term disability benefits under a different Chase insurance policy issued by Liberty — *Ellis' receipt of short term disability benefits under a different policy of insurance are not at issue here.* When Ellis' short term insurance coverage terminated and the Bank's group long term disability Policy became applicable to Ellis, Liberty began an investigation into Ellis' possible qualification for long term disability benefits. While the Company was investigating Ellis' long term disability claim, it also paid her long term disability benefits. By paying Ellis long term

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1. *Cook v. Liberty Life Assurance Co. of Boston*, 320 F.3d 11, 22 (1st Cir. 2003) does not support Ellis' argument that the definitions of total and partial disability are not mutually exclusive. (Pet. at 18 n.2). In truth, *Cook* stands for the proposition that, while total disability benefits are available to persons who cannot work at all, partial disability benefits are to be paid *only* when an individual is actively (albeit on a limited basis) working. *Cook*, 320 F.3d at 22 n.11. The court summarized the relevant policy provision as follows: "someone who is partially disabled and thus *unable to work full-time* can receive a 'Loss of Earnings Monthly Benefit' to make up for some of the gap between her *former salary* and her *part-time salary.*" Such an individual, however, must not earn "more than 20% of her former salary. . . ." (emphasis added). *Id.* at 22.

disability benefits during the investigatory period, the Company ensured (whatever the final outcome of the inquiry) that Ellis would not go without compensation between the time her short term benefits ran out and Liberty completed its probe (which, in this case, lasted for more than six months).

Had Liberty not paid long term disability benefits to Ellis during the investigatory period, Ellis would have had no means to support herself during the six month investigatory period even if Liberty ultimately determined that she was totally disabled within the meaning of the Policy — a waiting period likely to be harmful to legitimate claimants for disability benefits. Erring on the side of caution (by paying Ellis benefits during the course of the Company's investigation), Liberty, of course, ran the risk of never recouping monies it overpaid Ellis if Ellis was not, in fact, disabled within the meaning of the Policy. In the end, this is exactly what happened.

Specifically, based on the evidence contained in Ellis' short term disability file, as well as new (and substantial) evidence the Company gathered from sources such as Ellis' physicians, her lawyer, an independent medical examiner, Liberty's nursing staff, and private investigators, Liberty terminated its inquiry on December 22, 2000 concluding that Ellis was not totally disabled within the meaning of the Policy. Ellis appealed Liberty's decision in January 2001, and she and her attorney submitted additional evidence to the Company. Liberty considered this information, but determined that it would not change the outcome of Ellis' case; therefore, Liberty upheld its claim denial in March 2001. *Liberty did not seek to recover its overpayment of long term disability benefits made to Ellis between May and December 2000.*

Based upon its belief that Ellis' initial qualification for short term disability benefits (under a different policy of insurance) and Liberty's decision to pay long term disability benefits while the Company investigated the long term disability claim estopped Liberty from denying that Ellis was totally disabled, the district court granted, in part, summary judgment in favor of Ellis and denied, in part, summary judgment in favor of Liberty. The Court of Appeals for the Fifth Circuit reversed and rendered judgment in favor of Liberty (and affirmed that part of the judgment already favorable to Liberty), holding simply that the Company did not abuse its discretion in denying the long term disability claim and terminating benefits. Consistent with this Court's, other Circuit Courts of Appeal, and Fifth Circuit precedents, the panel re-stated the oft-cited proposition that a district court must affirm the decision of a plan fiduciary when substantial evidence supports a decision to deny or terminate ERISA-covered benefits.

REASONS FOR DENYING THE PETITION

I. Review is not Appropriate Because the Result Reached by the Court of Appeals for the Fifth Circuit was in Full Accord With Supreme Court Authority.

To support her claim that the panel decision is in conflict with Supreme Court precedent, Ellis implies that the lower court erred because it did not "credit [her] reliable evidence of disability, including the opinions of the insured's treating physicians;" failed to "discuss[]" (to her liking) "the considerable medical evidence provided by Ellis' treating physicians or the factual information Ellis provided;" did not give "considerable weight" to a Social Security Disability Insurance ("SSDI") claim determination; and allowed an affidavit to "trump" deposition testimony. (Pet. at 16, 21, 27). She also chastises the panel for failing to make more than a "vague reference" to each piece of evidence contained in the administrative record. (Pet. at 27).

These evidence-based disagreements with the Court of Appeals amount to nothing more than a request for the Supreme Court to correct perceived errors in: (i) fact (*e.g.*, whether Ellis' treating physicians' records were contradictory, whether the objective tests demonstrated that Ellis had some work capacity, whether the independent medical examiner's assessment was correct, and whether Liberty should have relied upon videotaped surveillance and private investigation reports); and (ii) application of the law, as stated in *The Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 123 S. Ct. 1965 (2003) and *Cleveland v. Policy Mgt. Sys. Corp.*, 526 U.S. 795, 119 S. Ct. 1597 (1999), to the specific facts of her case (*e.g.*, "what weight should the court have given the treating physicians' records, SSA determination, affidavit, and deposition testimony?"). This Court has cautioned that such issues "rarely" rise to the level of compelling reasons to grant *certiorari*. SUP. CT. R. 10. Indeed, over the past five years, the Court has denied *certiorari* in at least 15 disability plan cases which raised similar issues.[2]

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2. *See UNUM Life Ins. Co. v. Fought*, No. 04-1000, 2005 WL 218389 (May 2, 2005); *Nord v. The Black & Decker Disability Plan*, __ U.S. __, 125 S. Ct. 62 (2004); *Harrell v. CNA Ins. Co.*, __ U.S. __, 125 S. Ct. 43 (2004); *Reliance Standard Life Ins. Co. v. Lasser*, __ U.S. __, 124 S. Ct. 2390 (2004); *Wagner v. First Unum Life Ins. Co.*, __ U.S. __, 125 S. Ct. 416 (2004); *Maniatty v. UNUM Provident Corp.*, 540 U.S. 966, 124 S. Ct. 431 (2003); *Farfalla v. Mutual of Omaha Ins. Co.*, 540 U.S. 875, 124 S. Ct. 222 (2003); *Fallo v. Piccadilly Cafeterias, Inc.*, 537 U.S. 1002, 123 S. Ct. 487 (2002); *Marx v. Meridian Bancorp, Inc.*, 537 U.S. 885, 123 S. Ct. 128 (2002); *Marshall v. Delta Family-Care Disability and Survivorship Plan*, 534 U.S. 1162, 122 S. Ct. 1173 (2002); *Cochran v. Trans-General Life Ins.* Co., 534 U.S. 887, 122 S. Ct. 198 (2001); *Razvi v. Guarantee Life Ins. Co.*, 534 U.S. 1041, 122 S. Ct. 617 (2001); *Perez v. Aetna Life Ins. Co.*, 531 U.S. 814, 121 S. Ct. 49 (2000); *Conley v. Pitney Bowes, Inc.*, 528 U.S. 1136, 120 S. Ct. 979 (2000). By contrast, since

(Cont'd)

Moreover, even if the issues Ellis raises could be said to be of some national import, the Fifth Circuit's opinion is consistent in every respect with *Nord* and *Cleveland*. First, those cases stand for the proposition that regulations and caselaw developed under the Social Security Act ("SSA") are not generally applicable to other types of disability cases such as those arising under ERISA or the Americans with Disabilities Act ("ADA"). *See e.g.*, *Nord*, 538 U.S. at 832-35, 123 S. Ct. at 1971-72 ("of prime importance" is to recognize that "critical differences" exist between SSA and ERISA); *Cleveland*, 526 U.S. at 803-05, 119 S. Ct. at 1602-03 (comparing and contrasting SSA with ADA). Thus, in *Nord*, this Court rejected the importation of the SSA's "treating physician rule" into ERISA cases, and in *Cleveland*, this Court held that the SSA and ADA are just dissimilar enough that an ADA plaintiff should be allowed to "explain" why differences existing between assertions she made in an ADA lawsuit and those made in an SSA proceeding are inconsequential. *Nord*, 538 U.S. at 832-34, 123 S. Ct. at 1971-72. *Cleveland*, 526 U.S. at 805-06, 119 S. Ct. 1603-04.

(Cont'd)

the passage of ERISA, this Court has granted *certiorari* in only 5 disability plan cases. *See Nord*, 538 U.S. 822, 123 S. Ct. 196; *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 119 S. Ct. 1380 (1999); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 107 S. Ct. 1542 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S. Ct. 3085 (1985). In each of the cases in which this Court granted a petition for *writ of certiorari*, some issue of national significance, with which the lower courts struggled, surfaced — such as whether to adopt the SSA's "treating physician rule" in ERISA cases (*Nord*), the scope of ERISA's preemption and savings clauses (*Ward, Taylor, Dedeaux*), and whether an ERISA fiduciary could be held personally liable for compensatory or punitive damages (*Russell*). Even a case once deemed "certworthy" lost its luster because the petitioner, like Ellis here, sought a second review solely to correct perceived errors in the lower court's judgment. *See Nord*, __ U.S. __, 125 S. Ct. 62.

Therefore, to the extent the Fifth Circuit rejected the notion that Ellis' treating physicians' opinions were not entitled to greater weight than an independent doctor's findings, the court correctly applied the law. The court also properly followed Supreme Court precedent to the extent that it decided the SSA disability determination — which relied on statutory language substantially different from the Policy's language, was subject to detailed regulations and regulatory presumptions not found in ERISA, and was rendered based on evidence other than that contained in the ERISA administrative record — was not dispositive of Ellis' ERISA claim.

Second, with respect to the question of what weight should be given a post-deposition affidavit, this Court, in *Cleveland*, recognized that the lower federal courts "have held with virtual unanimity" that, though a party cannot "simply" contradict a deposition with a subsequent affidavit, she nonetheless, has the right to "explain[]" apparently disparate statements. *Id.* As a result, Ellis' admission that Liberty's litigation manager sufficiently accounted for her so-called inconsistent statements militates against Supreme Court review of this matter. (*See* Pet. at 16) ("in a post-deposition Affidavit, McGee *explained* that she was confused by this [deposition] question. . . ."). Consistent with this admission, the Fifth Circuit described in considerable detail the reasons the witness' explanation was worthy of credence. *Ellis v. Liberty Life Assurance Co. of Boston*, 394 F.3d 262, 271 (5th Cir. 2004) (deposition question confused witness, Company consistently interpreted total disability provisions of Policy, and other witnesses corroborated affidavit testimony).

Finally, Ellis has not cited, and Respondent has not found, any authority for the proposition that an appellate court errs by failing to identify, and describe the relevance of, each

piece of evidence in the administrative record when rendering a decision in an ERISA case. Such a rule is unsound because it would waste precious judicial resources while adding little, if anything, of value to the parties' or general public's understanding of the legal issues involved.

In any event, if Ellis' concern is with the veracity of the appellate court, the Fifth Circuit noted numerous times in its opinion that "substantial evidence" existed in the lengthy administrative record to support Liberty's decision. *Ellis*, 394 F.3d at 267, 271, 274 & nn.23, 27. These notations, combined with various procedural safeguards (*i.e.*, the Fifth Circuit only decided this matter after reading the parties' briefs, reviewing the record on appeal, hearing oral arguments, and correcting its initial opinion), are sufficient indicators that the panel took its job seriously, considered all of the information the parties submitted, and crafted a well-reasoned opinion.

II. Review is not Appropriate Because no Circuit Split Exists on the Questions Ellis Presents.

With respect to the lower federal courts, Ellis does not identify a true "split" in the circuits. Instead, she parses unique facts from wildly different lawsuits to advocate that a national "uniformity" standard govern the interpretation of all ERISA disability plans. (Pet. at 16) (urging this Court to adopt a rule that would "promote uniformity of construction of disability insurance policies"). Ellis' argument is both illogical (given that the abuse of discretion standard *presumes* different fiduciaries will interpret different language in different plans differently, the circuit courts can *never* split over this issue) and against public policy (to the extent "[u]niformity" is truly "vital to the purposes of ERISA," it is Congress' province to dictate what benefits, if

any, employers shall provide under ERISA).[3] *See Nord*, 538 U.S. at 833, 123 S. Ct. at 1971 (quoting *Lockheed Corp. v. Spink*, 517 U.S. 882, 887, 116 S. Ct. 1783, 1788 (1996)) (Congress has not seen fit to require employers to provide any specific type or level of ERISA benefits); *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358, 119 S. Ct. 1380 (1999) (discussing Congressional action/inaction with respect to regulation of insurance companies); *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 113-17, 109 S. Ct. 948, 956-57 (1989) (if plan confers "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," courts review decisions for an abuse of discretion).

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3. Moreover, Congress *has* expressed its will by declaring, for instance "the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1011. Congress has also stated that "any State law which regulates insurance" shall not be subject to ERISA preemption. 29 U.S.C. § 1144(b)(2)(A). Thus, unless Congress intervenes, it is the States to whom the right to determine whether "uniform" standards of insurance contract interpretation are desirable, is reserved, providing yet another reason that this Court should avoid taking action upon Ellis' request. In any case, Ellis' argument is taken (out of context) from an unbroken line of Fifth Circuit cases dating to 1979 that stand for the proposition that the "uniformity" test applies to a plan administrator's interpretation of a particular plan's provisions over time, but not to other plan administrators' interpretations of other plans (even when those other plans contain the same or similar language). *See, e.g., Ellis*, 394 F.3d at 270 (three factors, including "whether the administrator has given the plan a uniform construction" are relevant in determining whether interpretation was legally correct); *Bayles v. Central States, Southeast & Southwest Areas Pension Fund*, 602 F.2d 97, 99-100 & n.3 (5th Cir. 1979) (first applying uniformity test). *See also Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 109, 109 S. Ct. 948, 953 (1989) (citing *Bayles* for use of arbitrary and capricious standard in older ERISA cases).

As a result, courts should not apply some "cookie-cutter" interpretation of "disability" to every ERISA-governed insurance policy issued by every insurance company to every type of employer in every part of the Country. Supporting Liberty's view, even a cursory examination of Ellis' authorities reveals that each case is either unique and fact-specific, or is in *agreement* with *Ellis*. For example, the Tenth Circuit decided *Caldwell v. Life Ins. Co. of North America*, not based on issues of plan interpretation, but because the administrator made erroneous *factual* determinations. *Caldwell v. Life Ins. Co. of North America*, 287 F.3d 1276, 1283-86 (10th Cir. 2002) ("administrator admitted that she based her decision in part on the determination of the workers' compensation judge . . . despite not knowing 'what the standard was in Kansas'" to qualify for workers' compensation benefits, "administrator also ignored evidence," administrator "based her decision on a skewed reading of Mr. Caldwell's medical records," and "administrator also misconstrued Mr. Caldwell's testimony. . . .").

Kinstler v. First Reliance Standard Life Ins. Co., dealt with, among other issues, "the appropriate standard of review . . . when an ERISA claim is denied because of an adverse determination . . . with respect to a *factual* question." (emphasis added) *Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 245 (2nd Cir. 1999). Specifically, the administrator depended upon an incorrect description of Kinstler's job duties. *Id.* at 248. Also, in contrast to this case in which the parties agree that the abuse of discretion standard applies, "the *de novo* standard of review applie[d]" in *Kinstler* because the insurance policy granted no "clear reservation of discretion to the plan administrator." *Id.* at 245.

Another reason *Kinstler* is inapplicable is because the language in that insurance policy was vastly different from that which appears in the Policy under consideration today:

> "Totally Disabled" and "Total Disability" mean that as a result of an Injury or Sickness . . . an Insured

> cannot perform the material duties of his/her regular occupation. We consider the Insured "Totally Disabled" if due to an Injury or Sickness he or she is capable of only performing the material duties on a part-time basis or part of the material duties on a Full-time basis . . . .

Id. Finally, Ellis is simply incorrect when she says the *Kinstler* court conducted a wholesale review of the definition of disability. In actuality, the Second Circuit contemplated only what meaning to give the words "regular occupation" and "material duties" — terms that were not considered by the Fifth Circuit in *Ellis*. *Id.* at 248-49.

Not only is *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan* distinguishable on its facts, its analysis is actually *consistent* with *Ellis*. While the plan administrator in *Saffle* did abuse its discretion by arbitrarily adding a "reasonable accommodation" requirement that did not exist in, and was contrary to, the plain language of the plan, the *reason* that interpretation was legally incorrect was because it defined plan terms in a way that "effectively convert[ed] benefits for total disability into benefits for partial disability" — the exact same problem that exists with the "uniform standard" Ellis now proposes for all insurance policies. *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 456-59 (9th Cir. 1996). Notably, Ellis glosses over the *Saffle* court's most relevant holding:

> we cannot say that the Committee lacks discretion to construe 'each and every duty of [the participant's] regular occupation' to mean *all of the substantial and material duties of her regular occupation*. To the extent this is what the Committee meant, its construction is consistent with the plain language of the Plan because it

> assumes that the participant is "completely unable to perform each and every duty" that matters.

Id. at 459 (emphasis added).

Next, Ellis relies on *McClure v. Life Ins. Co. of North America*, 84 F.3d 1129 (9th Cir. 1996). That *per curiam* opinion is distinguishable because: (i) the insurance policy did not provide discretionary authority to the administrator and, as a result, the court reviewed the decision *de novo*; (ii) the administrator stipulated that McClure "was *unable to perform all of the physical tasks required of him . . .*;" and (iii) the insurance policy used a different definition of disability. (emphasis in original) *McClure*, 84 F.3d at 1133-34. In contrast to Ellis' assertions, the Ninth Circuit never held that an "each and every" definition of disability was improper. Rather, on the facts presented (the insurance policy apparently did not provide partial disability benefits for a person who could perform some, but not all, of his job duties), the lone phrase "inability .. . to perform every duty" was ambiguous. *Id.* at 1134. Such ambiguity, however, cannot be found in a policy, such as the one Liberty issued to Chase, that provides both total and partial disability benefits. *See Ellis*, 394 F.3d 271-72. *Accord id.* at 278 (conceding "to construe the policy differently than the administrator would create an internal inconsistency between the policy provisions for total disability and partial disability) (Pickering, J. dissenting).

Turning to *Hammond v. Fidelity & Guar. Life Ins. Co.*, 965 F.2d 428 (7th Cir. 1992), other than using a *de novo* review standard, that case, like *Saffle*, is in harmony with the Fifth Circuit's decision. Instead of discrediting any language from the insurance policy, the court relied on *Torix v. Ball Corp.*, 862 F.2d 1428 (10th Cir. 1988) to find that, with respect to "'general' disability provision[s]" (those

which provide benefits for persons unable to work in any occupation), "the insured should be entitled to recover provided he or she is unable to perform *all* of the substantial and material acts necessary to the prosecution of some gainful business or occupation." (emphasis added) *Hammond*, 965 F.2d at 430-31. Because Hammond's husband was capable of performing all of the material and substantial duties of a job, Hammond was not entitled to disability benefits and summary judgment in favor of the insurer was proper. *Id.*

What Ellis fails to mention about *Hammond* is that the Seventh Circuit made a distinction between general disability provisions and "occupational disability" provisions like the one considered by the Fifth Circuit in *Ellis*. *Id.* The two types of clauses are "substantial[ly]" different because occupational disability provisions "provide[] benefits if the claimant is unable to perform *his regular job*. . . ." (emphasis added) *Id.* *Accord Ellis*, 394 F.3d at 270 ("the LTD Policy provides that benefits are initially payable only to an employee who is 'unable to perform *all* of the material and substantial *duties of his occupation*. . . .'") (emphasis added). Given this distinction, even if the Seventh Circuit had expressed displeasure that general disability clauses require claimants to prove an inability to perform "each and every" duty of some occupation (which the court did not do), its holding would have been limited to general disability clauses and policies, not an occupational clause such as the one at issue in *Ellis*.

Ellis also cites *Torix* in support of her "conflict" argument, but that case too, as the court recognized, turned on "a question of fact that depends upon all the circumstances of [the] case." *Torix*, 862 F.2d at 1430 (quoting *Helms v. Monsanto Co.*, 728 F.2d 1416, 1420 (11th Cir. 1984)). Specifically, the general (as opposed to occupational) disability plan at issue in *Torix* provided benefits to workers

who were "prevented from engaging in any occupation," but apparently did not provide benefits for partial disability. Like *Hammond*, the issue of whether using an "each and every" standard under an occupational disability plan was proper, simply never came up. Instead, the court borrowed from insurance and social security cases, the concept of "gainful activity or employment." *Id.*, 862 F.2d at 1431. Thus, if Torix could "establish a physical inability to follow any occupation from which he c[ould] earn a *reasonably substantial income* rising to the dignity of . . . [a] livelihood," then he was disabled and, therefore, entitled to benefits. (emphasis added) *Id.* Here, of course, Ellis' situation is demonstrably different — she still has the ability to perform most of the material and substantial duties of her own job; therefore, unlike Torix, she also has the ability to earn a "substantial income" as a loan officer at a bank. *Ellis*, 394 F.3d at 270-74.

Finally, *Helms* does not help Ellis' quest for *certiorari*. *Helms*, of course, also turned on "a question of fact. . . ." *Helms*, 728 F.2d at 1420. Setting aside that the Monsanto plan too was a general, not occupational, disability insurance policy, the physician before whom the parties agreed to arbitrate their dispute testified that he believed Helms was not entitled to benefits unless he "had no 'conscious life.'" *Id.* at 1419-20. Such a standard was obviously contrary to the plain language of the plan which stated that benefits were due in the event a worker was "prevented . . . from engaging in any occupation for remuneration or profit. . . ." *Id.* ("such a standard would render the entire Monsanto [plan] totally meaningless.").

The court also made clear that, because this was a general disability policy review, the inquiry would focus on the meaning of "remuneration or profit," an issue not present when, as here, a court considers an occupational disability

provision. *Id.* (people almost always retain some "ability to earn a nominal sum unless . . . rendered completely immobile and without cognitive ability."). Interestingly, the Eleventh Circuit recognized that, in state insurance cases, disability is usually defined to mean (similar to the Chase Policy here) "unable to perform *all the substantial and material* acts of some gainful business or occupation." (emphasis added) *Id.* at 1420-21. *Helms*, therefore, is also consistent with *Ellis*.

In the end, Ellis' attempts to manufacture conflict where none exists must fail. Faced with the same set of circumstances, the courts to which Ellis refers in her petition, given their reasoning and analyses, would likely reach the same result as the Fifth Circuit. Accordingly, Supreme Court review is not warranted.

III. Review is not Appropriate Because the Panel's Decision is in Full Accord With Fifth Circuit Precedents.

Next, Ellis contends that the decision in this case conflicts with prior Fifth Circuit precedent. Not so: neither the panel nor *en banc* court perceived any so-called conflict. Consequently, they denied Ellis rehearing. Nevertheless, to bolster her conflict argument, Ellis cites *Lain v. UNUM Life Ins. Co.*, 279 F.3d 337 (5th Cir. 2002), a case that is so factually distinct from this matter as to be valueless.

In particular, *Lain* never discussed the propriety of an "each and every" standard as Ellis implies. The case also involved a different standard of review (*de novo*), insurance company (UNUM Life Insurance Company), employer (Schlanger, Mills, Macer & Grossberg), and ERISA plan than those considered by the *Ellis* court. *Lain*, 279 F.3d at 342.

Most importantly, the Schlanger Mills plan contained substantially different language than that found in the Chase

Policy, defining disability as meaning a person "cannot perform *each* of the material duties of [her] regular occupation. . . ." (emphasis in original) *Id.* Construing this precise phrase, the Fifth Circuit noted it was dissimilar to language found in a policy like Chase's. *Id.* at 344-45. According to the court:

> a senior benefit analyst at UNUM, testified that he interpreted the first-prong of the definition of "disability" as requiring Lain to be unable to perform *all* of her material duties before she would be considered disabled. *This is contrary to the plain language of the Policy* and to UNUM's interpretation of the same definition in other cases.

(emphasis added) *Id.* at 345. The contention, therefore, that *Ellis* and *Lain* are in conflict is simply false — the court found that the language of the two policies is nothing alike. *Id.*

Nor does the Court of Appeals' decision conflict with *Vercher v. Alexander & Alexander, Inc.*, 379 F.3d 222 (5th Cir. 2004). As with *Lain*, *Vercher* involved a different insurance company (Metropolitan Life Insurance Company)[4], employer (Alexander & Alexander, Inc.), ERISA plan, and plan language (disability means "completely unable to perform any and every duty of your occupation").[5] *Vercher*, 379 F.3d at 231. While the *Vercher* language could be said to be ambiguous, the court declined the opportunity to consider

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4. Adding to the dissimilarities, MetLife acted as a third party administrator, *not* an insurer in the *Vercher* case. *Vercher*, 379 F.3d at 231.

5. The Fifth Circuit found significant that Alexander & Alexander's ERISA plan did not provide for partial disability benefits. *Compare Vercher* 379 F.3d at 229 & n.9 *with Ellis*, 394 F.3d at 271-72 & n.23.

any interpretation issues. *Id.* ("we need not determine whether the interpretation . . . was an abuse of discretion"). It did not have to: irrespective of whether the phrase "completely unable to perform any and every duty" meant Vercher was *not* disabled if she *could* perform any trivial job or that she *was* disabled if she could *not* perform any trivial job:

> MetLife essentially determined that, if there were something she was unable (despite reasonable accommodation) to do that was indispensable or essential to the proper performance of her regular occupation, she would have received benefits. However, so long as she was able to perform all the substantial and important aspects of her job, with reasonable accommodation, and any aspects of the job that she could not perform with reasonable accommodation were, singularly or together, *not* indispensable or essential to the job, then she was not disabled.

(emphasis in original). *Id.*

For that reason, the Fifth Circuit held that "either under a *de novo* or an abuse of discretion standard, the defendants applied a legally correct definition of disability" based on that particular plan's language. *Id.* As a result, the background discussion of the law in another circuit, which provided context, but was not the holding of the case, was mere *dicta* and is not controlling. *See, e.g., Jama v. Immigrations & Customs Enforcement*, __ U.S. __, 125 S. Ct. 694, 706 n.12 (2005) ("[d]ictum settles nothing, even in the court that utters it."); *McDaniel v. Sanchez*, 452 U.S. 130, 101 S. Ct. 2224 (1981) ("dictum unnecessary to the decision in that case . . . is . . . not controlling in this case. . . .").

Further, contrary to Ellis' assertions, the court did not so much as hint that a "completely unable to work" standard is *per se* inappropriate.[6] Rather, the Fifth Circuit concluded that the district court erred in using a "completely unable to work" criterion solely because "it does not appear that the district court's definition . . . was the one that Alexander and MetLife actually applied . . . ." *Id.* at 230.

Next, Ellis says that, according to the dissent, the Policy was ambiguous. (Pet. at 19). A careful reading of the opinion, however, reveals that the dissent was in *agreement* with the majority on this issue. Although the dissent admitted that it would like to interpret the Policy another way, it ultimately concluded that Liberty's interpretation was "reasonable" and any other interpretation "would create an internal inconsistency" in the Policy rendering it meaningless. *Compare Ellis*, 394 F.3d at 278 (any interpretation other than Liberty's would create "an internal inconsistency") (Pickering, J., dissenting) *with Ellis*, 394 F.3d at 271-72 & n.23 ("Ellis's proffered interpretation . . . cannot be squared with the Policy's language" and would render Policy provisions "meaningless surplusage . . . .").

IV. Review Is Not Appropriate Because no Other Court is Likely to Reach a Different Result Based on the Unique Facts of This Case.

Finally, this Court should not issue a *writ of certiorari* to the Fifth Circuit because the lower court's decision, under the unique facts of this case, was right. Specifically, Chase's Policy, which provides for the payment of total disability payments to an individual who is "unable to perform the

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6. Even if it had, that interpretation is not consistent with Liberty's interpretation of the Chase Policy. *Ellis*, 394 F.3d at 270-72 (totally disability means "unable to perform all of the *material and substantial* duties of his occupation. . . ." (emphasis added)).

material and substantial duties of [her] occupation," authorizes Liberty to use its discretion to interpret Policy terms and make benefits determinations. *Ellis*, 394 at 266. In the exercise of the discretion, Liberty has consistently interpreted the Policy to mean that a person who can perform some material and substantial job duties is not entitled to total disability benefits. *Id*. at 271. To the extent such a person is entitled to partial disability benefits, she must be working in some capacity. *Id* at 271-72.

Based on substantial evidence in the administrative record, including information the Company received from Ellis, her doctors, her attorney, an independent medical examiner, the Company's nursing staff, and private investigators, Liberty determined that Ellis could indeed work, but was currently unemployed. As a result, the Company acted properly in terminating Ellis' benefits. Other courts, faced with the same set of facts, would likely render a similar decision. Therefore, it would be a waste of precious judicial resources for the Supreme Court to consider this case.

CONCLUSION

In the end, Ellis seeks this Court's review only to correct what she perceives to be errors in the decision below and to advocate for changes to ERISA's statutory regime. While significant to litigants, error correction "rarely" presents an issue so nationally important as to require Supreme Court intervention. This is especially true in a case like this one which presents unique factual circumstances. Likewise, the structural changes to ERISA that Ellis seeks are more properly left to Congress following investigation and debate. Finally, Ellis wants to change the way Texas regulates its insurers, she should be lobbying the State Legislative, not this Court.

Therefore, Respondent Liberty Life Assurance Company of Boston respectfully requests that the Supreme Court deny the petition for *writ of certiorari.*

Respectfully submitted,

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